

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 12/16/17/20th 61/10/18

PRINTED: 11/07/2017
FORM APPROVED
OMB NO. 0938-0391STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

445254

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

11/01/2017

NAME OF PROVIDER OR SUPPLIER

ONEIDA NURSING AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

18805 ALBERTA DR

ONEIDA, TN 37841

(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)(X) PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETION
DATE

F 000

INITIAL COMMENTS

F 000

Plan of Correction

Oneida Nursing and Rehab
Center, 11/01/2017F 371
SS=F483.60(i)(1)-(3) FOOD PROCURE,
STORE/PREPARE/SERVE - SANITARY

F 371

(i)(1) - Procure food from sources approved or
considered satisfactory by federal, state or local
authorities.(i) This may include food items obtained directly
from local producers, subject to applicable State
and local laws or regulations.(ii) This provision does not prohibit or prevent
facilities from using produce grown in facility
gardens, subject to compliance with applicable
safe growing and food-handling practices.(iii) This provision does not preclude residents
from consuming foods not procured by the facility.(i)(2) - Store, prepare, distribute and serve food in
accordance with professional standards for food
service safety.(i)(3) Have a policy regarding use and storage of
foods brought to residents by family and other
visitors to ensure safe and sanitary storage,
handling, and consumption.This REQUIREMENT is not met as evidenced
by:Based on review of facility policies, observation
and interview, the facility failed to store food items
in a sanitary manner in 3 of 4 refrigerators

This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ D. WING _____		(X3) NAC SURVEY COMPLETED 11/01/2017
NAME OF PROVIDER OR SUPPLIER ONEIDA NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 18805 ALBERTA DR ONEIDA, TN 37841		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 371	<p>Continued From page 1</p> <p>observed and failed to date 1 container of food in 1 of 4 refrigerators observed affecting 54 residents.</p> <p>The findings included:</p> <p>Review of the facility policy "Food Storage" dated 1/12/16 revealed "...Foods...should be stored in airtight containers..."</p> <p>Review of the facility policy "Trayline Refrigerated Leftover Storage" dated 1/1/14 revealed "...Date container with use by date..."</p> <p>Observation and tour of the kitchen with the Certified Dietary Manager (CDM) on 10/30/17 from 9:30 AM-10:30 AM revealed 1 unsealed plastic storage bag with bologna, 1 unsealed plastic storage bag with cheese, and 1 unsealed plastic storage bag with whipped topping in the stand-up refrigerator.</p> <p>Interview with the CDM on 10/30/17 at 10:00 AM, in the kitchen confirmed the food items were not stored in a sanitary manner.</p> <p>Observation of the nourishment refrigerator for the 400 and 500 Hall with the Minimum Data Set (MDS) Coordinator on 10/31/17 at 2:30 PM, revealed 1 unsealed plastic storage bag with bologna and sliced cheese.</p> <p>Interview with the MDS Coordinator on 10/31/17 at 2:30 PM, in the 400 and 500 Hall nourishment room confirmed the food items were not in a sealed container and were not stored in a sanitary manner.</p> <p>Observation of the nourishment refrigerator for</p>	F 371	<p>F 371</p> <p>Compliance Date: 11/16/2017</p> <p>Immediate action taken for the resident found to have been affected include:</p> <p>No residents were identified as being affected by the deficient practice.</p> <p>The food found in the standup refrigerator in the dietary department not stored in a sanitary manner was discarded on 10/30/2017 by the dietary manager.</p> <p>The food found in the nourishment refrigerators was discarded on 10/31/2017 by the administrator.</p> <p>Identification of other residents having the potential to be affected.</p> <p>All residents have the potential to be affected.</p>		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 84VG11

Facility ID: TN7607

If continuation sheet Page 2 of 3

Jessica Shepherd

Administrator

11/13/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/01/2017
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NAME OF PROVIDER OR SUPPLIER

ONEIDA NURSING AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE:

18805 ALBERTA DR
ONEIDA, TN 37841

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F 371	Continued From page 2 the 700 hall with the Assistant Director of Nursing (ADON) on 10/31/17 at 2:45 PM, revealed 1 unsealed plastic storage bag of sliced cheese. Continued observation revealed 1 plastic container of greens undated in the refrigerator. Interview with the ADON on 10/31/17 at 2:45 PM, in the 700 Hall nourishment room confirmed the food items were not stored in a sealed container and were not stored in a sanitary manner. Continued interview confirmed the container of food was not dated.	F 371	Actions taken/systems put into place to reduce the risk of future occurrence. An in-service education program on proper sanitary storage of food was conducted by the Certified Dietary Manager on 11/01/2017 for the dietary staff. The nursing staff had education 11/01/2017 on the storage of food in the nourishment areas refrigerators by the Director of Nursing. The education on sanitary storage of food will be completed by 11/16/2017 the dietary manager and the Director of Nursing.	

FORM CMS-2567(02-00) Previous Versions Obsolete

Event ID: G4VG11

Facility ID: TN7002

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Jessica Shepherd

Administrator

11/13/17

Division of Health Care Facilities

PRINTED: 11/07/2017
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/01/2017
NAME OF PROVIDER OR SUPPLIER ONEIDA NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 18805 ALBERTA DR ONEIDA, TN 37841		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies During the Licensure survey conducted on 11/1/17, at Oneida Nursing and Rehab Center, no Health deficiencies were cited under Chapter 1200-08-06, Standards for Nursing Homes.	N 002	<p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The dietary manager will audit the standup refrigerator 5 days a week for two weeks then three times a week four weeks to assure that food items are stored in a sanitary manner. The nursing supervisor will audit the nourishment refrigerators 5 days a week for two weeks then three times a week for four weeks to assure food items are stored in a sanitary manner.</p> <p>The Dietary Manager will present the results of audits to the Quality Assurance Performance Improvement Committee for review and further recommendations for two months. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice.</p>		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/CLIA REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

64VG11

If continuation sheet 1 of 1